Community HealthChoices (CHC) Waiver Amendment Comments

Amendment Effective 1/1/2022

Please fill in the information below when submitting your comments, including the specific sections of each Appendix on which you are commenting.

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Agency: Pennsylvania Health Law Project

Date Submitted: September 19, 2021

Section of Application	Comment
Main Module:	
Appendix A:	
Appendix C:	
Appendix C-1/C-3 Service Definitions:	See attached comments regarding the following service specifications: • Participant-Directed Community Supports • Personal Assistance Services • Home Adaptations • Nursing Services • Specialized Medical Equipment and Supplies PHLP supports the proposed amendments to the following service specifications: • Personal Emergency Response System (PERS) • Vehicle Modifications
Appendix D:	
Appendix E:	See attached comments.
Appendix H:	
Performance Measures:	

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PENNSYLVANIA Health Law PROJECT

Pennsylvania Health Law Project's Comments on the Proposed Amendments to the Community HealthChoices Waiver

Submitted September 19, 2021

Thank you for the opportunity to submit these comments on the Office of Long-Term Living's proposed amendments to the 2022 Community HealthChoices (CHC) waiver. The Pennsylvania Health Law Project's (PHLP) comments draw on our extensive experience working with CHC participants navigating the CHC waiver and reflect our commitment to a CHC program that is truly person-centered, values participant experiences and supports participants in their goals of community integration and independent living.

I. Appendix C-1/C-3 Waiver Service Specifications

1. Comments on Personal Assistance Services (PAS) and Participant-Directed Community Supports (PDCS) Service Specifications

a. Clarify the proposed language regarding the need for informal supports to be "available, willing and able" to provide Personal Assistance Services or Participant-Directed Community Supports.

We appreciate OLTL proposing language aimed at ensuring that informal supports are available, willing and able to perform personal assistance services (PAS) or participant-directed community supports (PDCS) services. However, we are concerned that the proposed wording will embolden MCOs to continue making erroneous assumptions about the availability of informal supports and inappropriately place the onus on those supports and participants to show, in every case, that anybody around them is not available, willing and able to provide PAS/PDCS.

Our clients' experiences are that MCOs believe the mere existence of a family member or friend within the participants' orbit allows the MCO to deny services, placing the burden on those individuals to provide uncompensated care without any person-centered evaluation of whether doing so is feasible or appropriate. Moreover, even when alleged informal supports make clear that they are not available, willing and able to provide uncompensated care at all or in the amount the MCO expects, MCOs still cite the existence of informal supports as a basis for denying services. Below are a handful of PHLP's numerous cases in which MCOs have relied on the assumed availability and willingness of informal supports to provide care as a basis for denying PAS.

- AR, who is quadriplegic due to a gunshot wound, requires assistance with all ADLs and IADLs. His MCO cut his PAS hours in half and upheld that decision at the grievance on the sole basis that "Personal Assistance Services hours are approved … when no one else is available to provide assistance. You live with your informal support including your mother and brother who are available to provide assistance." In denying the PAS hours, the MCO ignored testimony presented at the grievance hearing that the participant lives in a separate unit attached to the home, that the alleged informal supports were already providing unpaid support beyond the hours for which formal PAS was received, and that neither were available to provide additional informal supports to make up for the cut in PAS hours.

- MC sought an increase in PAS at a "trigger event" needs assessment. In discussing the bases for upholding the denial, the MCO's grievance decision relied, in part, on its view that MC's family should be providing informal supports, without regard to explicit grievance testimony that the family was not available or willing to provide uncompensated care. The MCO's decision notes, "Personal Assistance Services hours are approved to provide hands-on assistance to help you complete activities of daily living when no one else is available to provide assistance. … You live with your two daughters and grandchild. Your daughter is your caregiver." The "caregiver" daughter is a formal support for 15 hours per week and otherwise unavailable to provide unpaid care because she has two other jobs. The other daughter also works outside the home and is not willing to provide unpaid assistance during the hours she is home.. The grandchild is four years old.

- HE is a 75-year-old who has dementia and wanders. Her MCO reduced her PAS by 67 percent stating. "you live with your grandson who can offer informal support." That the MCO placed the burden on the grandson to provide uncompensated care is evident in its statement that he "can offer informal support," suggesting, as is the case, that he had not made such an offer, nor had the MCO determined that he was available, willing and able. The grandson was not able to provide informal support due to his work schedule.

- DC, who lives alone and has no informal supports had her PAS hours cut by more than half. Nevertheless, the MCO's written rationale for the reduction erroneously states, "Received 15 hours informal support within the 3 day look back. Informal supports are willing/able to continue providing assistance."

It is critical that the waiver make clear that it is the responsibility of the MCO – through the person-centered service planning process – to assess and document the availability, willingness and ability of informal supports to provide uncompensated care. This includes ensuring that the MCO, the participant **and** the proposed informal supports are all in agreement as to the scope and type of services that will be provided by the informal support and when they will be provided. We urge OLTL to make the following changes to the proposed amendment to the PAS/PDCS service specifications:

PAS services [Participant-Directed Community Supports] are provided only for the participant and not for other household members, and only when the MCO determines and documents ~~shows~~ that neither the participant nor any~~one else in the household, relative or~~ adult informal ~~caregiver~~ support, such as a household member or relative, is regularly available, willing and able to perform such activities for the participant and where no community/volunteer agency or third-party payer is capable or responsible for their provision.

Informal supports are unpaid supports that are provided voluntarily to the participant in lieu of PAS [Participant-Directed Community Supports] and other HCBS services. Informal supports may not be compelled. When a participant uses informal supports in lieu of PAS [PDCS], the MCO must discuss with and document in the PCSP each informal support's availability, willingness and ability to provide PAS [PDCS] and the participants' acceptance of assistance from that informal support. The PCSP also must identify each informal support, and, with respect to each informal support, the day(s) and number of hours per day informal supports is provided, as well as the specific type and scope of services provided.

The above language aligns the CHC waiver with the federal HCBS waiver regulation that defines informal or "natural" supports as "unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports"[1] and CMS's comment accompanying the regulation that notes the voluntariness language was specifically added to the definition to clarify that the waiver service "planning process must not compel unpaid services."[2] Requiring MCOs to confirm and document proposed informal supports' availability, willingness and ability to provide services; the participants' acceptance of those services; and details on the scope of informal supports to be provided, acknowledges the important role that informal supports play in providing services to participants and will help ensure gaps in care do not occur due to misunderstandings of roles. There is precedent for formally requiring such documentation in Pennsylvania. For EPSDT nursing and home health services an MCO may not deny services unless there is "adequate documentation that substantiates the parent or caregiver is actually able and available to provide the child's care during the time hours are requested."[3]

Because the critical role informal supports play is not limited to PAS and PDCS, we further urge OLTL to incorporate the above two-sentence definition of informal supports and language requiring detailed assessment and documentation of informal supports in PCSPs to CHC Waiver Appendix D, Section D-1(d) (Service Plan Development Process) and the 2022 CHC Agreement. Doing so acknowledges the role

[1] 42 CFR § 441.301(c)(2)(v)
[2] 79 FR 3008 (emphasis added); see also, Application for a §1915(c) Home and Community-Based Waiver Instructions, Technical Guide and Review Criteria (Jan. 2019) at 305 ("Informal caregivers are relatives, friends or others who volunteer their help." (emphasis added)).
[3] MCOPS Memo # 07/2016-008, "Guidance Regarding the Review of Requests for Skilled Nursing, Personal Care Services, Including that Provided by Home Health Aides" at 2.

of informal supports and reinforces the requirement of a comprehensive discussion of informal support roles in the person-centered planning process.

b. Clarify the PAS service specification by removing the "primarily hands-on assistance" language.

PHLP strongly urges OLTL to clarify the PAS service specification, by removing the "primarily provide hands-on assistance" language. When PHLP made this suggestion last year, OLTL commented that, "'Hands-on' is defined as relating to, being or providing direct practical experience or actual personal involvement which would include tasks such as cuing and supervision of participants which are included as PAS activities in the current service definition." However, while the PAS service specification mentions cuing and supervision, the detailed definition of "hands-on" only exists in the comments section of the 2021 waiver; it is not a part of the PAS service specification. It should be if the "primarily provide hands-on assistance" language is not removed. Reviewers, such as grievance panels, external review entities and administrative law judges who are not specifically provided the waiver comment are not aware of the scope of that term.

The current emphasis on hands-on assistance as primary is to the detriment of participants whose cognitive impairments necessitate primarily supervision and cuing to initiate and complete activities and for whom hands-on assistance is secondary or minimal. It also impacts participants who need supervision to perform tasks safely such as a person with dysphagia who needs supervision while eating to prevent choking, or a person who is a fall-risk who needs supervision for transfers and ambulation.

Continuing to include the "primarily provide hands-on" assistance language at the beginning of the PAS service definition taints the reading of the rest of the definition such that any non-hands-on assistance is viewed as of lesser importance. Consequently, MCOs have undervalued and failed to properly account for time needed for non-hands assistance for cuing and supervision, or outright denied PAS hours for time spent providing supervision or cueing. PHLP client CM's recent denial and grievance decision exemplify the problem:

> CM requested an increase in her PAS hours. The MCO acknowledged CM's need for supervision with some ADLs and IADLs, but explicitly declined to authorize PAS for any of those tasks. It only authorized PAS for those tasks for which her InterRAI showed a need for hands-on assistance. Specifically, the denial notice stated, "You said you were able to complete daily tasks such as eating, transferring, bed mobility, and walking with supervision only. Based on your answers, the 15 hours per week of Personal Assistance Services you currently receive meets your needs. The 15 hours per week covers your request for assistance with meal prep, housekeeping, bathing, toileting, personal hygiene, dressing upper and lower body and locomotion."
>
> The subsequent MCO grievance decision upholding the PAS denial made clear that the MCO viewed PAS as only appropriate for hands-on

assistance by again distinguishing those tasks that require supervision from other tasks for which assistance is needed: "Personal Assistance Services hours are approved to provide hands-on assistance to help you complete activities of daily living when no one else is available to provide assistance. … [Y]ou need help with housework, meal preparation, bathing, personal hygiene, dressing your upper body, dressing your lower body and toilet use. You need supervision with eating, toilet transfer, and getting in and out of bed."

Because OLTL agrees that PAS is not limited to hands-on assistance, we strongly urge revisions to the PAS service specification to make that expectation clearer which will prevent the misapplication of the "hands-on" language PHLP has seen too often in our cases. There is no policy reason not to do so. We propose the service specification be amended as follows:

> Personal Assistance Services ~~primarily provide hands-on assistance to participants that~~ are necessary, as specified in the service plan, to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Removing the language that gives inordinate weight to hands-on assistance will also better align the PAS definition with the companion language in the PDCS service definition, which reads, "Participant-Directed Community Supports are specified by the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the participant."[4]

If OLTL does not remove the "primarily provide hands-on assistance" language, then the definition of "hands-on" described in the 2021 waiver comments section should be added to the PAS service specification; to wit: "Hands-on assistance means relating to, being or providing direct practical experience or actual personal involvement which includes tasks such as cuing and supervision of participants."

c. <u>Further amend the proposed language regarding overnight PAS to clarify that the listed tasks are not exclusive and include cuing, and that there is no requirement that a participant be awake to receive overnight assistance.</u>

PHLP does not oppose the addition to the PAS service specification of examples of the types of PAS that might be performed overnight, **provided that the language is further amended to make clear that the list of examples is not exhaustive and includes cuing. If OLTL does not make these clarifications, we oppose adding the examples.**

PHLP has clients with overnight needs not among the examples in the revised service specification, such as a need for assistance adjusting a CPAP, or supervision and cuing to prevent wandering. We are concerned that MCOs will view the addition of

[4] 2020 HCBS Waiver at 199.

examples as an exclusive list resulting in denials of overnight PAS for clients who have other nighttime needs for assistance.

In response to a question at the August 5, 2021 MLTSS meeting, OLTL's Patty Clark confirmed that the list of overnight tasks is not exhaustive. We urge OLTL to clarify this in writing by simply adding "but is not limited to" after the word "includes" in the service specification.

We also ask that OLTL add cuing to the way overnight assistance may be provided. Based on our experience with MCOs denying PAS for non-hands-on assistance described above, we are concerned that the failure to include "cuing" along with "physical assistance and supervision" in the examples of overnight PAS will be interpreted by MCOs as cuing not being an appropriate method of performing overnight assistance.

Finally, we ask that OLTL add language clarifying that while overnight PAS requires awake staff, it does not require the participant to be awake. At a fair hearing this year, an MCO attorney argued a participant must be awake to receive overnight PAS and we have also heard from participants that their services coordinators have told them this as well. To eliminate this confusion, we urge OLTL to insert clarifying language that explains the participant may be asleep while receiving overnight PAS.

To implement the above recommendations, we urge OLTL to amend the PAS service specification as follows:

> Overnight PAS provides intermittent or ongoing awake, overnight assistance to a participant in their home for up to eight hours. This assistance includes, but is not limited to, the following: physical assistance, cuing or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication. The participant's PCSP must document an assessed need for this service beyond what can be provided through Personal Emergency Response System (PERS) or TeleCare services. Overnight PAS requires awake staff. A participant need not be awake to receive overnight PAS.

d. Do not prohibit compensation of live-in caregivers for providing PAS or PDCS in the form of supervision for safety of participants.

We appreciate OLTL's assurances that it will withdraw from the proposed waiver amendment language that would have prohibited for the first time compensating direct care "workers who live in the same residence as the participant … for providing supervision to the participant." We strongly urge OLTL to refrain from reintroducing that prohibition in future proposed amendments to its waivers and will vehemently oppose such an amendment should it be put forward.

Prohibiting individuals who live with a participant from being compensated to provide supervision for safety will harm hundreds if not thousands of CHC participants –

PHLP has had more than 180 clients since CHC began who receive some amount of supervision for safety, along with other PAS, from a paid caregiver with whom they live. Prohibiting people with whom someone lives from being compensated for assisting with a document need for supervision for safety would represent a sea change in the CHC waiver and will disproportionately impact participants with dementia, traumatic brain injury, and other cognitive impairments who rely on live-in caregivers whom they trust to keep them safe in the community. Moreover, if the intent of such an amendment is cost savings for the MCOs, it will not serve that purpose. Based on PHLP's experience, most live-in paid caregivers, including those who provide supervision for safety, would not be able to provide the same services without compensation – it would be financially infeasible for them. Therefore, other, non-live-in paid caregivers would take their place undercutting any savings while simultaneously forcing participants to accept care from someone who was not their first choice.

2. Comment on the Home Adaptations Service Specification

a. Clarify that an accessible bathroom may be added regardless of whether it increases the square footage of the home, and allow the addition of an accessible bathroom when retrofitting an existing bathroom is not feasible.

We urge OLTL to add language clarifying that building an accessible bathroom is an exception to the home adaptation prohibition on building a new room. As written, a person can only have an accessible bathroom added if it increases the square footage of the home. This is because the section in the home adaptation service specification prohibiting increasing the square footage of a home makes an exception for bathrooms, but a separate section of the same service specification prohibiting adding a new room has no exceptions. PHLP had a client who appeared to have been denied the addition of a new accessible bathroom on this basis, as the MCO treated the request for an accessible bathroom in the living room as "remodeling" (the client did not follow-up, so we were unable to complete our investigation). Therefore, we urge OLTL to add to the wavier language that resolves the conflict between the blanket prohibition on "[b]uilding a new room" and the ability to add a bathroom that increases the square footage as noted above.

We also urge OLTL to expand the circumstances in which the addition of an accessible bathroom is appropriate. Currently, a new bathroom can only be built if the cost of doing so "is less than retrofitting an existing bathroom." However, there are circumstances where the reason an existing bathroom cannot be retrofitted is because it is not feasible to do, such as where structural limitations make adding sufficient turn space in an existing bathroom impossible.

We propose the following amendment to address both the above concerns:

> Building a new room is excluded, except when necessary for the addition of an accessible bathroom. Specialized Medical Equipment and Supplies is excluded. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the participant this includes items that are

not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom or when retrofitting an existing bathroom to meet a participant's needs is not feasible.

3. Comment on the Nursing Services Specification

a. Revise the Nursing Services specification so that nursing services can be provided simultaneous with PAS and community-based respite.

We urge OLTL to revise the Nursing Services specification to allowing nursing to be provided simultaneously with PAS and respite. At the outset, it is rare for someone to need both nursing and PAS or respite simultaneously. Nevertheless, there are participants whose needs are so significant that they require ongoing nursing as well as additional assistance that a nurse could not perform on their own. Examples include a person who needs a two-person assist for transfers and bathing, or a participant who needs continuous monitoring and assessment by a nurse, while a second person performs tasks outside of the home such as shopping. For clients with needs like this, nursing is generally needed side-by-side with PAS or informal supports during some portion of each day. Removing the prohibition on providing nursing simultaneously with PAS will ensure such participants get the care they need. Removing the prohibition on providing nursing simultaneous with in-home respite will allow informal caregivers to take a break from caregiving knowing that their loved ones are receiving a sufficient level of care for both their nursing and non-nursing needs.

PHLP has clients with a simultaneous need for continuous nursing and PAS. For example:

- GN has Duchenne's muscular dystrophy, is vent-dependent and has quadriplegia. He is completely dependent on others for all ADLs/IADLs and extensive skilled nursing needs. He receives 24/7 nursing but also needs PAS as he requires two people for all transfers, incontinent care, repositioning, bathing, and dressing. He also requires someone to do his shopping while his nurse provides skilled care.

- JR suffered a traumatic brain injury in a motor vehicle accident that left her minimally conscious, completely dependent on others for all movement and activities, and vent dependent. She requires nursing, but because she is a two to three person assist with transfers and all other care, a nurse alone cannot provide all her care. She requires a combination of nursing, paid caregivers and informal support.

To allow people like GN and JR to receive the medically necessary nursing and PAS services that allows them to maintain their health, welfare and safety in the community, we urge OLTL to make the following amendments to the nursing services definition:

Long-term or continuous nursing cannot be provided simultaneously with ~~Personal Assistance Services,~~ Adult Daily Living Services, or Residential Habilitation Services ~~or Respite Services~~. Short-term or intermittent nursing can be provided simultaneously with Residential Habilitation Services, Personal Assistance Services or Respite Services. The CHC-MCO may consider an exception to the limitation on long-term or continuous nursing and Residential Habilitation Services with documentation from the Service Coordinator that supports the participant's need to receive both services.

4. Comment on Specialized Medical Equipment and Supplies Service Specification

a. Clarify that PPE is covered for use by the participant, their direct care workers, and their informal supports.

PHLP supports the permanent addition of personal protective equipment (PPE) to the Specialized Medicap Equipment and Supplies service specification, but urges OLTL to clarify that the covered PPE is appropriate for use by the participant as well as their direct care workers and informal supports. As written the PPE would only be permitted for the participant to wear themselves. We proposed the following amendments:

> Personal Protective Equipment (PPE) ~~for participants~~, such as gloves, gowns and masks for participants, their direct care workers and informal supports, can be obtained under Specialized Medical Equipment and Supplies. PPE may be added to a participant's PCSP without the need for a physician's prescription. This does not supplant the Occupational Safety and Health Administration (OSHA) requirements under 29 C.F.R. § 1910.132 for agencies to provide PPE to their workers.

II. Appendix E: Participant Direction of Services

a. Restore supports brokers for Services My Way.

We reiterate our opposition to last year's elimination of support brokers from the waiver and urge OLTL to restore the position. The Services My Way model places even greater responsibilities on the waiver participant than regular participant-directed services due to the need to stay within a budget and to find community supports and goods and services from non-waiver vendors. In eliminating the role last year, OLTL noted, "The support broker activities are currently being provided either by PPL (the F/EA) or by the service coordinators. It is not feasible to implement a separate support broker function because it would be duplicative."[5] The experience of our clients who use Services My Way is that service coordinators do not understand the budgeting process and are not providing supports broker functions and that PPL – and the new F/EA the MCOs will hire – is not required to provide the level of support needed by

[5] 2020 CHC Waiver at 21.

Services My Way participants. One of our clients who uses Services My Way started with a service coordinator who didn't understand the program at all. She then spent over a year trying to educate her second service coordinator on how Services My Way is supposed to work and pointing to the types of support she needs. When the SC quit last month, the SC supervisor indicated to our client that she did not think anybody else was willing to do the work that the former SC had done to support the client. Meanwhile PPL was not returning our client's or PHLP's calls to trouble shoot issues.

b. Require the MCOs to explicitly provide additional support and training through their SCs and F/EA functions for users of Services My Way.

If OLTL will not restore the supports broker role, we ask that Appendix E be amended to ensure that the support broker duties that were eliminated from the 2021 CHC waiver be explicitly reassigned to the F/EA or service coordinator.

As stated above, in justifying its elimination of a separate supports broker function from the 2021 CHC Waiver, OLTL noted, "The support broker activities are currently being provided either by PPL (the F/EA) or by the service coordinators. It is not feasible to implement a separate support broker function because it would be duplicative."[6] To make good on the assurances that these functions are being performed by the F/EA and services coordinators, OLTL should amend the CHC Waiver as follows to include the duties which were formerly held by supports brokers and not currently the clear responsibility of either services coordinators or the F/EA:

Appendix E-1(a) Description of Participant Direction

In addition, individuals choosing to self-direct their services will receive assistance from their Service Coordinator to develop their person-centered service plan. Once the PCSP is developed, approved, and authorized, the Participant is responsible for arranging and directing the services outlined in their plan, with, as appropriate, information and support from the Service Coordinator. During the implementation and management of the PCSP, the Service Coordinator will:

- Assist the Participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the Participant to develop an individualized back-up plan;
- Assist the Participant to identify risks or potential risks and develop a plan to manage those risks. This includes a review of workplace safety issues and strategies for effective management of workplace injury prevention;[7]
- Recommend or arrange training on the topics of abuse, neglect, exploitation and abandonment as defined by protective services statues;

[6] Id.
[7] 2020 CHC Waiver, Appendix E-1 at 268.

- Monitor the provision of services to ensure the Participant's health and welfare; and
- Assist the Participant to secure training of support workers who deliver services that would require a degree of technical skill and would require the guidance and instruction from a health care professional such as a Registered Nurse.

Participants who choose to manage an individual budget will receive assistance from Service Coordinators to implement, modify[8] and manage the Spending Plan. The Service Coordinator will review and approve the participant's Spending Plan. Once the Spending Plan is developed, approved and authorized, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the Spending Plan, the Service Coordinator will assist the participant with the execution and development of the Spending Plan and monitor spending of the Spending Plan.

Appendix E-1(e) Information Furnished to Participant

The F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum developed by the CHC-MCOs or the F/EA and includes, at minimum, the following:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer; • The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks; •
- The process for resolving issues and complaints; and •
- Workers Compensation and the process for reviewing workplace safety issues and strategies for effective management of workplace injury prevention.[9]

Appendix E-1(j): Information and Assistance in Support of Participant Direction

Participants will obtain enrollment and informational materials from the CHC-MCO or selected F/EA organization under contract with the CHC-MCO. In addition, the CHC-MCO or F/EA is responsible for providing orientation and training to the participant prior to employing their direct care worker. Orientation is based upon a standard curriculum approved by OLTL and includes the following:

[8] Id. (Supports brokers assist with "Developing, modifying and negotiating an individualized Spending Plan.")
[9] Id.

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the F/EA;
- The process for receipt and processing timesheets and employee payroll checks;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues and strategies for effective management of workplace injury prevention.[10]

Individuals choosing to self-direct their services will also receive assistance and support from their Service Coordinator. The Service Coordinator will:

- Provide participants with information regarding self-direction on an ongoing basis, including information about responsibilities, rights and concepts of self-direction, including:
    - Effective hiring techniques including creating job descriptions, ads for hiring, strategies for evaluating candidates and informing candidate on selection or non-selection;
    - Techniques for interviewing and conducting reference checks;
    - Effective management and supervision techniques such as conflict resolution;
    - Proper procedures for termination of workers or communication with the Service Coordination Entity regarding the desire for termination of workers;
    - Techniques on scheduling paid and unpaid supports;
    - Techniques related to problem-solving, decision-making, and achieving desired outcomes within self-directed services; and
    - Assisting an individual to be a successful employer of self-directed services;[11]
- Work with the F/EA and the participant as necessary to ensure all enrollment and employment paperwork is completed and sent to the F/EA;
- Assist the participant to secure training of support workers who deliver services that would require a degree of technical skill, and would require the guidance and instruction from a health care professional such as a Registered Nurse;
- Recommend or arrange training on the topics of abuse, neglect, exploitation and abandonment as defined by protective services statues;
- Assist the participant in communicating with the F/EA as needed;
- Monitor under-utilization and over-utilization and contact the participant and the CHC-MCO to resolve potential service delivery problems

[10] Id.
[11] Id.

- Support the participant in problem-solving, decision-making, and recognizing and reporting critical incidents; and
- Monitor the provision and utilization of services to ensure the participant's health and welfare.

In addition to the above, the Service Coordinator is also responsible for the following activities when the participant chooses to exercise budget-authority:

- Explain the method for developing the individual budget and share the budget amount with the Participant during the PCSP process;
- Ensure that allowable expenditures for goods and services are made using the participant's individual budget;
- Counsel the participant on the budget and other issues as necessary;
- Develop systems or finding help to manage finances and resources;[12]
- Assist the participant with service plan modifications within limits of the individual budget; and
- Notify the F/EA regarding changes to the individual budget and spending plan.

[12] Id.